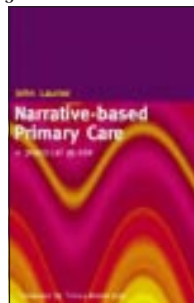


reviews

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Narrative-based Primary Care: A Practical Guide

John Launer



Radcliffe Medical Press,
£21.95, pp 272
ISBN 1 85775 539 1
www.radcliffe-oxford.com

Rating: ★★

As a general practitioner, I find the interviewing techniques presented in this book interesting. They look as if they might be useful to my patients and to me. Launer invites readers to structure their clinical conversations making use of the idea that knowledge occurs through the stories—the narratives—that we tell others and ourselves about our experiences.

In a usual clinical encounter the patient brings his story about his condition (which he may get a chance to tell to the doctor). The clinician develops her story on the basis of what the patient says and her professional knowledge. The clinician then tells her story to the

patient. Launer advises the clinician also to construct a new story jointly with the patient—a story that works for both of them. A good story is one that is coherent, aesthetically appealing, and useful for the patient.

Launer contends that this work can lead to the resolution of the patient's problem. The theoretical section of the book does not provide data to support this contention. However, the techniques are drawn from family therapy, and intended for use over the whole range of problems patients bring to the GP.

Taking examples from actual primary care practice, Launer presents the techniques in a clear, explicit fashion. He gives examples of questions that lead patients to think of their problem in new ways. These questions invite the patient to consider specific possibilities in one of several domains. Questions can relate to the family context—"What effect would it have on your wife if your back pain went away?"—or the geographical context—"How would things be different if you were still living in India?" Practitioners can invite patients to consider the effects of possible courses of action—"What would happen if you exercised every day?"—and the prerequisites and barriers to change—"What would need to happen in order for you to stop smoking?"

Most of the clinical examples concern people with psychological distress and/or

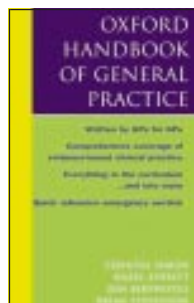
medically unexplained somatic complaints. However, GPs also deal with many people with chronic conditions. The process of co-construction of a new story is likely to be different when the practitioner believes that his own story is particularly "good" (that is, supported by extensive scientific data). The doctor talking to a patient who has had a myocardial infarction presents advice that is based on strong evidence, while the doctor bases his advice to the patient with fibromyalgia on much weaker data. There is much more room for movement by both parties in the latter situation than in the former.

Launer recognises the tension between patients' stories and those doctors' stories that are based on professional knowledge. However, discussion of this tension appears mostly near the end of the book. "How far should one go in pushing... versions of narrative thinking... that suggest that phenomena like strokes and death should be considered as mere consensual stories? How might one integrate a view of the world as composed from stories, with a scientific approach to knowledge and expertise" (p 198). The book provides us with almost no examples in which clinicians and patients negotiate these issues.

Ellen Rosenberg *associate professor of family medicine, Montreal, Canada*
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Oxford Handbook of General Practice

Chantal Simon, Hazel Everitt,
Jon Birtwistle, Brian Stevenson



Oxford University Press,
£22.95, pp 1060
ISBN 0 19 263270 1

Rating: ★★★

I remember getting a bit of a shock before my medical finals. Jovial consultants who had spent two and a half years telling us how the only thing that they had learnt at medical school was not to mix wine and beer

suddenly started looking serious. When teaching us, instead of regaling us with tales of drunken stupor from their past, they started murmuring about Bulstrode's triad, "of course," or Webber's test, "of course." It was the "of course" in particular that used to unsettle me.

I came to the conclusion that there must be some arcane text that I had somehow missed in my studies in which lay all those esoteric bits of information necessary for the initiate into medicine. There was no such text, of course. I was merely experiencing the embarrassing recognition that medicine is difficult.

But now there is such a text—in fact, several. The *Oxford Handbook* series will not tell you what Bulstrode's triad is, but the books do give an astonishing amount of highly compressed information. The *Oxford Handbook of General Practice* is of the same extremely high standard as the others. It is packed with all those bits of information you need twice a year and can't recall from last time—prescribing oxygen cylinders, causes of mononeuropathies, hyponatraemia, algorithms for warfarin, and so on. I have

reminded myself about investigation of secondary amenorrhoea, the incubation period of campylobacter, which thyroid carcinoma is the bad one, and details of the Mental Health Act 1983.

I really like the book's heavy clinical emphasis. GP registrars are usually shocked by the volume of varied clinical conditions that they meet in their training year. They moan that they get almost no formal training in the essential process of rapid and accurate assessment of presenting symptoms. They are urged to look for hidden agendas. But it is pointless looking for hidden agendas if you don't know how to manage the explicitly manifest ones. This book redresses the balance.

I would recommend it to every GP registrar together with *Clinical Evidence* (published by BMJ Books). The downside is that the print is small, which forces me to put on my reading glasses, which makes me look like my father, which makes me think about my age and mortality.

Kevin Barraclough *general practitioner, Painswick, Gloucestershire*

Items reviewed are rated on a 4 star scale (4=excellent)

Medicine and Art

Alan E H Emery, Marcia L H Emery



Royal Society of Medicine
Press in association with the
Royal College of Physicians,
£40, pp 112
ISBN 1 85315 501 2

Rating: ★★

Alan Emery is a distinguished British neurologist and an amateur painter; his wife, Marcia, is a librarian and trained psychologist. This book reflects their shared love of art and history, and contains more than 50 colour illustrations of works that portray the changing role of medicine in society. Each illustration is accompanied, on the opposite page, by a short article giving a succinct summary both of the career of the artist and the medical event illustrated. Fifteen of these articles have previously appeared in *Clinical Medicine*, the journal of the Royal College of Physicians.

The historical range is from a statue of Imhotep (physician to Pharaoh Djoser) from 2600 BCE to a *Lancet* cover from 2001 of Louise Riley's tapestry *The Patient and Researcher*. The book includes both well known and obscure artists and a wide variety of clinical activities. Traditional Indian Ayurvedic, Chinese, and Tibetan Buddhist

medical systems are praised for being holistic, whereas patients in the West are "disappointed by modern scientifically-based medicine."

I learnt that Goya's acute neurological illness in 1792 was probably Vogt-Koyanagi-Harada syndrome; that the process of metastasis was first recognised by Joseph Récamier; that in *Science and Charity*, painted in 1897, the 16 year old Picasso used his painter-father as the model for the doctor; and that Elizabeth Blackwell funded the completion of the Johns Hopkins Hospital and School of Medicine only on condition that it admitted women medical students. At the end of book is a list of medical conditions depicted in paintings.

The one black and white illustration is excellent. As with all but the most expensive books on art, there is the notorious problem that the colour reproductions are not of high quality. This might be because the publishers were given inadequate colour transparencies, or it might be down to poor printing or a failure to show the authors the final colour proofs. The last three art books that I read that had satisfactory colour pictures were printed abroad—two in Italy and one in China—and one of those books had to be withdrawn after publication and reprinted to a satisfactory quality.

I hope that the plates in the next edition of *Medicine and Art* will fill the whole or almost the whole of the pages rather than leave large white margins. It would be helpful to have an index of artists, to put the



Detail from *Le Tubage* by Georges Chicotot (1904)

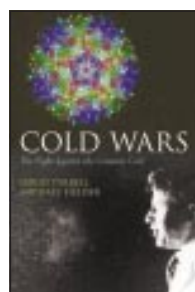
medium and the measurements in the legends, and to place the names of copyright holders in an appendix.

Jeremy Hugh Baron *honorary professorial lecturer, Mount Sinai School of Medicine, New York*

Competing interest: JHB is a fellow, and has been a member of council, of both the Royal College of Physicians and the Royal Society of Medicine.

Cold Wars: The Fight against the Common Cold

David Tyrrell, Michael Fielder



Oxford University Press,
£19.99, pp 253
ISBN 0 19 263285 X

Rating: ★★★

Who hasn't had a cold, or indeed colds, in the past 12 months? Probably no one reading this review, unless you spent the time completely isolated—for example, on an Antarctic weather station or on Tristan da Cunha. Yet the cold, the commonest of all illnesses, has no prophylaxis and no effective cure. This in spite of the longest list of suggested therapies for any disease, ranging from John Wesley's advice in 1747 to "pare very thin the yellow rind of an orange, roll it up inside and thrust a roll into each nostril" to Nobel laureate Linus Pauling's prescription of a daily dose of 12 g of vitamin C.

Despite all the immediate difficulties of postwar Britain, the Medical Research Council established the Common Cold Research Unit in Salisbury in 1946 in a disused American hutted hospital. Until the unit closed in 1990, its research team produced a fascinating and steady stream of basic and clinical research into the common cold and related viral infections. Much of this work was carried out on thousands of human volunteers, many of whom returned year after year to be inoculated with a dose of cold virus (or dummy control), and to live for a week in comfortable, well fed isolation.

In this nicely written and illustrated book, Dr Tyrrell, who ran the research programme at the unit from 1957 until its closure, together with the writer Michael Fielder, trace the history of the common cold from the early Egyptians—there are hieroglyphics for the nose and for coryza (catarrh) next to each other—to the present. Professor Walter Kruse, of Leipzig, a distinguished bacteriologist, who shared with Shiga the identification of the dysentery bacillus, first showed that a filterable agent could transmit the common cold from the nasal secretions of a patient to volunteers. This was published in 1914 and the first world war put paid to further studies in Kruse's laboratory. It was not until the 1930s that the viral nature of the disease was firmly established.

The work at the Common Cold Research Unit, as described in this volume, is fascinating from many aspects. The virologists there successively identified the cold viruses, grew them in culture, and characterised their structure. Work on the human volunteers detailed the exact mode of spread—droplets from the nose rather than the patient's fingers or fomites—and established that an extraordinary variety of claimed "preventions" and "cures," including interferon, were ineffective.

The studies spread far and wide from Salisbury. Interesting investigations were carried out at the British Antarctic Survey Station, on the islanders of Tristan da Cunha, and on volunteers on the isolated Seal Island, off the west coast of Scotland. Outbreaks of colds occur as soon as these communities are in contact with the outside world. Even the psychological aspects of colds were studied. Indeed, there was an apparent association between stress and increased susceptibility to infection.

Doctors, related professionals, and interested lay readers will find much to fascinate them in this book. It illustrates beautifully the vagaries, difficulties, false pathways, raised hopes, crashing disappointments, tedium, and all too rare but wonderful moments of medical research.

Harold Ellis *emeritus professor of surgery, University of London*

NETLINES

- Many medical libraries have been quick off the mark in establishing an online presence. Medlib (www.medlib.netfirms.com), which describes itself as the medical library gateway, claims to be the largest directory of medical library websites. MedLib has links to more than 750 medical library websites, which are catalogued by continent. There is the facility for visitors to feed back information about any library website that is not yet included. This is a good database with plenty of practical value to a global audience.

- Anyone looking for information on essential drugs and medicines—"those that satisfy the priority healthcare needs of the population"—should check out the World Health Organization's offering (www.who.int/medicines/). There is an explanation and brief overview of the subject with listings containing links to a large number of relevant documents and resources, such as a model formulary.

- For data about all things to do with chlamydia, visit www.chlamydiae.com, which has a section for the general public and another for health professionals. The site is text heavy and contains several excellent documents; navigation is straightforward and there is a superb links section. Part of the site is password protected, but to register you just have to complete a simple online form.

- The next time that you are asked an awkward science based question (perhaps by a child!) you might find it helpful to visit ScienceNet (www.sciencenet.org.uk). This is a free service that even has a telephone helpline for UK users. The site has a large archive of questions and answers in the popular science field, and these can easily be accessed by a search engine or via the quick links drop-down box, both of which are available from the home page. Medical science is well represented.

- Isabel (www.isabel.org.uk) is a sophisticated site dedicated to helping doctors dealing with paediatric cases. Named after a girl who fell seriously ill with complications resulting from chickenpox, this is a cutting edge website built from a solid database of paediatric information. One of the star features is a tool that offers a list of potential differential diagnoses according to the information entered. Other features include clinical algorithms and an image library. There is a registration process, but it is well worth the effort.

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DrHarry@diat.pipex.com

We welcome suggestions for websites to be included in future Netlines. Readers should contact Harry Brown at the above email address.



Lessons from the HRT story

The media must become more critical of unproven interventions

One of the more fascinating medical stories of recent times was that surrounding the findings of the women's health initiative trial of hormone replacement therapy.

This was not simply because the findings were so significant, in challenging long held assumptions about the merits of hormone replacement therapy (HRT) in disease prevention. Of equal interest has been the diversity of the medical profession's response to the findings.

The trial, part of which was published last year (*JAMA* 2002;288:321-33), showed increased risk of cardiovascular events from continuous combined oestrogen-progestogen hormone replacement, although it showed benefits for hip fractures and bowel cancer. The relative risks for invasive breast cancer, coronary heart disease, and stroke were increased, although the absolute risks were small.

Soon after the study's publication, Canadian epidemiologist Professor David Sackett wrote of the "arrogance" of preventive medicine in promoting unproven interventions and estimated that hundreds of thousands of healthy women had been harmed as a result of HRT's widespread use.

But others questioned or sought to downplay the significance of the findings. In Australia, eminent specialists were quoted in the media saying that the fallout from the study was a "beat up" and that women should continue to take HRT, and that it would be a "knee jerk reaction" to stop doing so.

Others said it could not be assumed that the findings would apply to other HRT products, and compared the increased breast cancer risk with that of having a few drinks a day. Another wrote: "No women on HRT should stop therapy simply because of poorly handled publicity which made mild risks seem like major ones."

Many specialists were critical of the media coverage and of the New South Wales Cancer Council, which issued a release highlighting the increased relative risk for breast cancer, for provoking public alarm.

Several months later, the dust is yet to settle. The Australasian Menopause Society (AMS) recently refused to endorse New Zealand guidelines on HRT, which had been updated to take account of the women's health initiative findings.

The guidelines, produced by the New Zealand Guidelines Group, say that com-

bined HRT is not recommended for long term use except in limited circumstances, that even short term use is associated with risk, and that HRT should be used only where menopausal symptoms are troublesome and women are fully informed of the risks.

The Australasian Menopause Society argues, however, that sections of the guidelines are "alarmist," "overly proscriptive," and likely to "become a useful tool for lawyers looking to cause trouble."

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists says that it is still reviewing the guidelines.

The varying reactions to the women's health initiative findings can be viewed in many lights. They reflect the scientific process of critical assessment of new findings; that interpretation of evidence inevitably involves subjective judgment; the difficulty of coming to terms with unexpected new evidence and of relinquishing entrenched beliefs and practices; the varying perspectives of clinicians versus those with a broader, population based focus; and battles over professional turf.

They may also reflect damage control. For industries confronted with negative research, a major aim of crisis management—as the tobacco industry has so ably shown—is to create confusion and argument about the significance of the findings.

Many have criticised the media's coverage of the study for provoking unnecessary alarm by reporting the increase in relative risk of harms, rather than the absolute risk. The irony, of course, is that the presumed benefits of HRT in preventing heart disease were widely promoted, through the media and elsewhere, in terms of relative risk reduction, as are many other medical interventions.

Another criticism of the media might be that for many years we were too ready to promote enthusiasts' beliefs about the benefits of HRT—whose very name, some argue, is a marketing rather than a scientific term.

We often failed to ask the experts that we quoted enough tough questions about what evidence was available to support their claims, or about their conflicts of interest.

We also often failed to appreciate that studies providing evidence suggestive of benefit—laboratory research, studies looking at surrogate measures in humans (such as effect on cholesterol), and observational studies examining the differences between women who elected to take HRT and those who didn't—provided less reliable evidence than randomised trials such as that of the women's health initiative.

It's not only the medical profession and drug regulators who have had a painful lesson from this study. The media also have a lesson to learn about the pitfalls of premature enthusiasm for unproven interventions and uncritical amplification of experts' claims.

Melissa Sweet *freelance journalist specialising in health and medicine in Australia*
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PERSONAL VIEW

The inside story on prison health care

I can speak from first hand experience about the lack of health care within the prison service, albeit from the perspective of the much over populated female estate.

The job of being a prison doctor is hard. Many inmates are drug users or self harmers. They pull fast ones to get legal prescriptions to alleviate the gnawing need for heroin or crack cocaine. They try to get sick notes so they do not have to work. However, not all prisoners are addicts or skivers, yet we are treated as if we are. On the "out," as it is colloquially known in prison, a general practitioner doesn't have to ascertain physically that someone has been up all night vomiting—his or her word is accepted as the truth. Unfortunately, someone residing at Her Majesty's pleasure is and always will be an inmate first and foremost.

From my experience there is a complete lack of health care for everyone. At HMP Drake Hall there is no night cover, and only three officers on for a population of 315 women, which is shocking. This led to one pregnant inmate being taken down to the segregation unit to miscarry—the segregation unit is the only place where there are officers constantly in attendance. We had no panic buttons in our cells to call for help in an emergency. Losing a baby is bad enough without being subjected to this type of dehumanising treatment.

Other inmates are the main carers for those who are sick and mentally ill. I personally telephoned Stafford Hospital's maternity unit, using my own valuable telephone units, in an attempt to get some help for the woman, only to be told that unless a directive came from the prison itself the hospital could do nothing. This inmate was finally transferred to HMP Foston Hall, which has a hospital wing. It was some days before the medical staff arranged a scan, only to discover that the inmate had been carrying twins and had lost only one. It is inconceivable that this could happen anywhere other than in prison.

So vast is the scale of mental health problems that accompany the physical needs of women in prison that it would take a team of highly trained and dedicated professionals to begin to come to grips with them. Most women in prison have been sexually abused either during childhood or in adolescence. These problems are greatly magnified simply because women come into prison with all their emotional baggage (unlike men, who "get their heads down and do their time" while their wives or girlfriends



Other inmates are the main carers

keep their lives intact for them.) Women have often left their children behind and are typically the sole or primary carers. Not knowing where the children are and not seeing them on a regular basis, if at all given the distances some mothers are placed away from their families, only makes matters worse. There are only 13 women's prisons in England and none in Wales.

Without doubt the most horrific thing that I have come across while in prison is "decrutching." This is the term used when a prisoner comes in with drugs secreted in her vagina and other inmates pin her down and remove those drugs with any available tool. This has led to serious injuries, which are all kept quiet because if the victim reports them, she will be charged with supplying. Female rape with implements—does it get any worse than this?

Finally a warning—hepatitis and HIV are rife in the female estate and most women conduct sexual relationships with other prisoners for all sorts of reasons. Many are also prostitutes when not in prison. These relationships go on without any protection or education at all. How long before the ticking bomb explodes into the wider population and everyone pays the price?

Penny A Mellor *advocate, Coven, Staffordshire*
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Competing interests: PM is a former inmate of three prisons and is currently involved in an investigation into the health care for pregnant prisoners that is being conducted by HMP Women's Estate.

SOUNDINGS

Count your blessings

"Ah, the children of the night..."

"Yeah yeah, what beautiful music they make yaddyaddyadda," I said, sitting well away, not from concern for my personal safety (a general practitioner should never show fear), but when your diet is fresh blood your breath stinks. "I'm a busy man, Count, skip the theatrics."

"I am in a most grave predicament," he said, in a rich deep voice, which would be ideal for flogging complementary medicines. "This warfarin—so many of my clients are taking it now that it is causing me considerable distress."

"There, there," I said, for even vampires deserve counselling, "tell me about it."

"I bite the neck, the blood flows, I lap it up with eager tongue, the blood clots, I stop. So it has always been. Now the bleeding does not stop, the blood is everywhere, up my nose, on my dress shirt—do you know how expensive these things are nowadays?—and I am a vampire, if I see blood I must drink of it. I even bring along a first aid kit, stick on a little bandage to stop the bleeding." He gave an embarrassed, mournful shrug. "Yet still I am putting on a little weight."

"You aren't comfortable with your body," I observed, comprehending, "hence the big castles."

"I don't feel good about myself, doctor. The ladies, they used to love me, they would lie there in those come-to-bed nightdresses, the intoxicating scent of garlic filling the air. I love garlic, you know, it's a little joke of mine." A wintry smile broke through, then his tone briefly became sharper: "This is confidential—right?"

"Of course," I said.

"Ah," he whispered, sad again, "how they would scream, how they would moan with rapture, and next morning pretend they remembered but a nightmare. Now they scream only because I am become so fat I am squashing them. 'Get off me, Porky,' said one.

"And it gets worse: when I transform into a bat, I am too heavy to take off, I flap and I flap and I flap but I remain squat on the ground; the children of the night, how they snigger and smirk at me. I now must climb the drainpipe, so undignified, what with the extra weight and all. Last night, the drainpipe came down; I got a pain in my chest, I'm breathless, and I'm having palpitations."

I examined him; the irony was thick. "Your pulse," I said, "is irregularly irregular..."

Liam Farrell *general practitioner, Crossmaglen, County Armagh*

If you would like to submit a personal view please send no more than 850 words to the Editor, BMJ, BMA House, Tavistock Square, London WC1H 9JR or email editor@bmj.com